DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PLACE AT MARYVILLE	2648 SEVIERVILLE RD MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure all fire wall construction is maintained. The findings include: Based on observation on January 7, 2013 from 2:15 p.m. and 4:30 p.m. revealed the following areas had penetrations or unapproved fire assembly in the fire rated wall. 1. Above ceiling at fire doors by room 314 2. Above ceiling at stairwell door across from room 312 3. Above ceiling at room 216 4. Above ceiling at fire doors by room 113 5. Above ceiling at fire doors at one (1) south	K 017	K-017 – Areas #1 - #5 have or will be sealed with approved rated fire caulk by 2/24/13. A walk through audit of the building has been completed to identify any other penetrations. The maintenance tech will conduct random audits throughout the building weekly for 4 weeks, then monthly for 3 months to check for any new penetrations. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	2/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa L. Brown	Executive Director	2-18-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 017	Continued From page 1 elevator by Life Styles Office. These findings were verified by maintenance and acknowledged by the administrator during the exit conference on January 7, 2013.	K 017	K-038 – The delayed egress door by room 140 was repaired on 1/8/13. A random audit of remaining delayed egress doors throughout the building was completed to check for functionality. The maintenance tech will conduct random audits throughout the building weekly for 4 weeks, then monthly for 3 months to check for proper functionality of delayed egress doors. The delayed egress signage will be installed on the two doors identified on the first floor One North activity room. A random audit of remaining delayed egress doors throughout the building was completed to check for proper signage. The maintenance tech will conduct random audits throughout the building weekly for 4 weeks, then monthly for 3 months to check for proper signage on the delayed egress doors.	2/24/13
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure exit access is readily accessible at all times. The findings include: Observation on January 7, 2013 at 10:57 a.m. and 12:20 p.m. revealed that upon testing of the delayed egress door by room 140 did not alarm or open upon testing. The delayed egress doors on the first floor one (1) North Activity room did not have delayed egress signage on two (2) of its doors. These findings were verified by maintenance and acknowledged by the administrator during the exit conference on January 7, 2013.	K 038		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the	K 056		

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K 056	Continued From page 2 building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the automatic sprinkler system was being maintained. The findings include: Observation on January 7, 2013 at 12:05 p.m. and 3:55 p.m. revealed the three (3) day emergency storage room has boxes stored too high to the ceiling obstructing the sprinkler coverage. Above ceiling in the corridor by the Plan Care Office wiring is attached to or supported by non system components of the automatic sprinkler system. These findings were verified by maintenance and acknowledged by the administrator during the exit conference on January 7, 2013.	K 056	The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate. K-056 – The storage room was brought into compliance with proper storage and proper clearance of the sprinkler system. The Director of Dining will conduct random audits of the storage room weekly for 4 weeks, then monthly for 3 months to check for compliance with proper clearance of the sprinkler system.	1/7/13
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A,	K 067		

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K 067	Continued From page 3 19.5.2.2 This STANDARD is not met as evidenced by: Based on record review, the facility failed to maintain their Heating, Venting, and Air Conditioning (HVAC). The findings include: Record review on January 7, 2013 at 10:30 a.m. revealed that no 4-year fire and smoke damper maintenance has been performed. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on January 7, 2013.	K 067	K-067 – 25% of all listed smoke dampers will be properly tested according to the standard by 2/24/13. The remaining fire and smoke dampers will be properly tested and maintained at a rate of 25% each year over the 4-year maintenance requirement. An audit will be performed to ensure that the 25% of smoke dampers were properly tested according to standards. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	2/24/13